ATTACHMENT A - RFP#720C-04050-06M

STANDARDIZED COMPREHENSIVE ASSESSMENTS FORMS

- 1.
- Virginia Pre-Admission Screening Mental Illness (MI) Level II Instrument (8 Pages) Virginia Pre-Admission Screening Mental Retardation (MR) and/or Related Condition (RC) Level II 2. Instrument (7 Pages)
- Virginia Pre-Admission Screening Dual (MI & MR or MI & RC) Diagnosis Level II Instrument (10 Pages) 3.

Virginia PRE-ADMISSION Screening Mental Illness Level II Instrument

SECTION I: IDENTIFICATION			
1. Name:	Managara (A)		
Last	First		MI
2. Gender: ☐ M ☐ F 3. DC	B:	4. Age:	
5. Private Pay: No Yes 6. Medicaid#:		7. SSN:	
8. CSB Name:	9. Evaluation D	vate:	
(Catchment Area)			
	☐ Home ☐ Ot		
11. LPASC: Co			(Title)
Address:	City:	State:	Zip:
Telephone: ()			
12. Per documentation in chart, does the individual have a LEG If "Yes", complete the following:	AL GUARDIAN? No	Yes	
Name:	Phone#: ()		
Address:	City:	State:	Zip:
Relationship: Parent Child Sibling Spo	ise Friend Other	(specify):	
13. DSM-IV Current Diagnoses: Axis I: Primary		Secondary	WARRANGO CONTROL OF THE STREET
Axis II: Primary		Secondary	
	on		
SECTION II: PSYCHOSOCIAL			
1. Marital status: ☐ Married ☐ Widowed ☐ Se	parated Divorced	☐ Single	Unknown
2. Education:			
☐ Less than high school ☐ Some high s☐ College grad ☐ Unknown		gh school graduate ecial Education	
3. Last full-time employment position held:			
4. Reasons for admission (check all that apply):			
☐ Convalescent care ☐ Fi☐ Decline in ADLs ☐ III	nr for personal safety nancial problems ness/disease ner (specify):	☐ Isolation☐ No primary can	•
5. Is this person able to evacuate a building in 3 minutes unassis	ted? N	o 🔲 Yes	

*	Name:
SI	ECTION II: PSYCHOSOCIAL (Continued)
6.	Provide history to substantiate MI diagnosis:
_	
_	
_	
7.	Are there current and ongoing family supports?
	Trease describe.
21	ECTION III; LEVEL OF FUNCTIONING
F100000	Basic Functional Status: Coding 1=Independent 2=Verbal Assistance 3=Physical Assistance 4=Dependent
() Transferring () Bladder () Bowel () Prepares for bed
() Toileting () Self medication () Eating () Dressing/undressing () Bathing () Personal hygiene () Brushing teeth () Selecting appropriate clothes
2.	Advanced Functional Skills: Coding 1=Independent 2=Verbal Assistance 3=Physical Assistance 4=Dependent
() Housework () Use of telephone () Use of money () Goes outdoors safely
() Care of clothing () Use of transportation () Manage finances () Treat minor ailments () Meal preparation () Shopping () Use of leisure time () Monitor health status
() Employment () Understands time () Respond to emergencies () Attend medical appts.
3.	Cognitive skills: Coding $I = Independent \ 2 = Verbal \ Assistance \ 3 = Physical \ Assistance \ 4 = Dependent$
() Prepares for daily activities () Understands 1 step instructions () Stays on task) Arranges for transport () Understands multi-step instructions () Completes assignments) Expresses needs and wants () Learns new skills () Transfers skills
4.	Sleep Pattern (mark one):
	☐ Normal ☐ Problems falling asleep ☐ Problems staying asleep ☐ Severely disturbed pattern
5.	Ambulation: (check as needed to describe resident's ability to ambulate)
	☐ Fully independent ☐ Unsteady ☐ Aids (cane/walker/assis.by 1) ☐ Wheelchair/indep. ☐ Wheelchair/assisted ☐ Chairfast or Posey support ☐ Bedfast ☐ Other (specify):

X*						Name:	
ECTI	ON III: LEVEL OF	FUNCTIONING (Cont	inued)				
	stive Devices: Describ tional capabilities:	be the extent to which co	orrective/adaptiv	e/prosthetic/r	nechanical devi	ces could improve the ind	ividual's
						WARREN	
						Historia de la companya de la compa	
			CORRECTION OF THE PROPERTY OF				
ECTI	ON IV: MEDICAL F	HSTORY					
	chotropic Medication						
Red			1			e in the last three months	·
_	Drug Code/Name	Purpose	Dosage	Freq	Change	Response to Rx	
ŀ							
ŀ							
-							
-							
L							
. SI In		ition of Medication he individual received a Yes	n emergency (ST	TAT) or PRN	administration	of medication to control h	ner/his beha
If	"yes," please indicate	ப் Tes the medication that was	administered an	ıd the behavio	or for which the	medication was administe	ered:
 3. Ph	ysician Review			<u> </u>			
Is a	physical examination	completed and signed b	y a licensed phy	sician in the l	ast 12 months a	ttached?	
	Yes, skip Physical As No, the Physical Exar	sessment. nination Supplement mu	st be completed	and signed by	a licensed phy	sician.	
4. Co	omments:						
5	QMHP Signature		<u>(</u>) Felephone Nu	mber	Date	

6		Name:	
SECTION V: PSYCHIATRIC ASSESSMEN	T - San		
1. Affective Behavior Observations			
a. Physical Features (mark all that apply):			
☐ Clean/Tidy ☐ Careless/Dishevelled/Sloppy ☐ Makeup or jewelry ☐ Non-seasonal clothing	☐ Normal stree☐ No apparent		-groomed ring bedclothes
b. Level of Consciousness (mark all that ap	oply):		
☐ Alert ☐ Drowsy ☐ Attentive	☐ Inattentive ☐ Lethargic	Other (specify):	1944
c. Manner (mark all that apply):			
☐ Warm ☐ Shy ☐ Silly ☐ Sincere ☐ Suspicious ☐ Easily frustrate	☐ Threatening ☐ Apathetic d ☐ Childlike	☐ Concerned about others ☐ Aggressive ☐ Reluctant to Respond	☐ Outgoing nature ☐ Sense of humor ☐ Other (specify):
d. Mood and Affect (mark all that apply):			
☐ Appropriate in quality and intens ☐ Flat or blunted ☐ Depressed ☐ Anxious, fearful or worried ☐ Angry, belligerent or hostile ☐ Delusional ☐ Suicidal ☐ Homicidal ☐ Other (specify):	ity to stated themes Mild Mild Mild Mild Mild Mild Mild Mild	☐ Moderate	☐ Severe
e. Form of Thought (check all that apply):			
Relevant Irre	oherent/Illogical elevant/Rambling ose Associations	☐ Blocking ☐ Impoverished ☐ Perseveration	☐ Tangentiality ☐ Circumstantiality ☐ Pressured
f. Orientation Level (mark one):			
☐ Oriented X3; clear at all times ☐ Oriented to person ☐ Confused at times in day ☐ Nonresponsive	Oriented to s	ituation Orie times at night Disc	nted to person and place nted to bathroom/bed riented X3
g. Communication Ability (check all that a	pply):		
☐ No problems ☐ Read ☐ Inappropriate content ☐ Stam	s	☐ Speech unclear/slurred ☐ Eye contact	☐ Gestures/aids ☐ Unresponsive
h. Socialization (mark all that apply):			
☐ Appropriately responds to others' ☐ Appropriately initiates contact with ☐ Inappropriate responses/interaction ☐ Withdrawn	h others		Name of the last

 \square Agitated

☐ Oppositional

Guarded

i. Attitude (mark one):

☐ Cooperative

·	Name:
SECTION V: PSYCHIATRIC ASSESSMENT (Continued)	
2. Chart of Behavior Complete the chart, based on all available infoindividual's medical records and staff commen	ormation for the last 3 months, including information from the sts:
Frequency	Frequency
☐ Dangerous smoking behavior	_ ☐ Destroys property
☐ Refuses medications	Exposes self
☐ Uncooperative diet	☐ Is sexually aggressive
☐ Uncooperative hygiene.	. Abusesverbally
Refuses activities	☐ Threatensverbally
Refuses to eat	☐ Threatensphysically
☐ Self-induces vomiting	Strikes othersprovoked
☐ Impatient/demanding	Strikes othersunprovoked
☐ Frequent/continuous yelling	☐ Talk of suicide
☐ Wanders	Suicidal threats
☐ Tries to escape	Suicidal attempts
☐ Seclusiveness	☐ Injures self
☐ Suspicious of others	Other (specify):
☐ Lies purposefully	Other (specify):
☐ Steals deliberately	None
3. Placement in Seclusion/Physical Restraints/Behavior Change(s)	
In the last 60 days, has the individual been placed in seclusion or other	hysical restraints to control dangerous behavior?
□ No □ Yes	
If "yes," describe the behavior and type of restraints:	
4. Comments:	

SE	ECTION VI: DETERMINATION RECOMMENDATION						
1.	Name:Last	First	MI				
2.	SSN:	3. Medicaid #:					
4.	The individual has, or may have, one or both of the following di	iagnoses:					
		eldition					
5.	As substantiated by your evaluation, does the individual meet the of a <u>primary</u> major mental illness?	e DSM-IV criteria for dementia or a related disorder in	the absence				
	☐ No, continue ☐ Yes, substantiate below						
	Rationale:						

6	6. As a result of a major mental disorder, the individual has functional limitations in the following areas (mark all that apply): a. Interpersonal functioning 1. Difficulty interacting appropriately/communicating effectively with other persons 2. A history of altercations, evictions, firing, fear of strangers 3. Avoids interpersonal relationships 4. Is socially isolated 5. Other (specify): 6. None b. Concentration, persistence and pace						
	 Difficulty in sustaining focused attention to comple Inability to complete tasks within established time p Makes frequent errors or requires assistance in the Other (specify): 6. None 	period					
	c. Adaptation to change						
	 1. Difficulty in adapting to typical changes associated 2. Manifests agitation, exacerbated signs and sympton 3. Withdraws from the situation 4. Requires intervention by MH or judicial systems 5. Other (specify): 6. None 	ns associated with the illness					
7.	As a result of a major mental disorder, the individual has requir	red treatment within the last two years for:					
	 ☐ Psychiatric treatment more intensive than outpatient ca ☐ Episodes of significant disruption to the normal living functioning at home, or in a residential treatment envir enforcement officers ☐ None 						

v	Name:
SECTION VI: DETERMINATION RECOMMENDATION (Continu	ued)
8. Does the individual meet the DSM-IV criteria for a serious mental il	Iness?
☐ No☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate below (P:☐ Yes, check at least one of the following and substantiate (P:☐ Yes, check at least one of the following	=primary S=secondary)
P S P □ 1. Anxiety disorder □ □	S □ 8. Panic disorder
☐☐ 2. Atypical psychosis ☐ ☐	9. Paranoid disorder 10. Schizoaffective disorder
4. Delusional disorder	11. Schizophrenia
	12. Somotoform disorder 13. Other (specify):
7. Mood disorder	14. Other (specify):
Rationale:	
9. SPECIALIZED SERVICES RECOMMENDATION	
Does the individual require specialized services for SMI (Inpatient p	psychiatric hospitalization) ?
☐ No ☐ Yes, Substantiate below	
Rationale:	
10. MENTAL HEALTH SERVICES RECOMMENDATION	
Does the individual require mental health services of a lesser intensi	ity? No Yes (Mark all that apply)
CURRENT MENTAL HEALTH SERVICES	RECOMMENDATIONS
	Continue Discontinue New
1. Psychiatric consultation	1.
2. Behavior management3. Day treatment/partial hospitalization	2.
4. Crisis intervention5. Outpatient psychiatric	4.
6. Psychotropic medication management	6. 🗌 🔲 🔲
☐ 7. Psychosocial rehabilitation ☐ 8. Targeted case management	7.
9. Other, specify	9. 🗌 🔲 🔲
Justification/comments:	
Justification/comments:	
11. Print Assessor's Name:Title:	Telephone:()
Psychiatrist/QMHP Signature:	Date:

		Name:	
SECTION VII: DMHMRSAS OFFICE USE ONLY MI/MR AUTHOR	ITY FINAL DE	TERMINATION	
N. A. N. C. V.	P-1		December 1
Meets NF Criteria	☐ Yes	☐ No	
Specialized Services Determination for SMI	☐ Yes	☐ No	
Mental Health Services	☐ Yes	☐ No	
☐ 1. Psychiatric Consultation ☐ 2. Behavior Management ☐ 3. Day Treatment/Partial Hospitalization ☐ 4. Crisis Intervention ☐ 5. Outpatient Psychiatric ☐ 6. Psychotropic Medication Management ☐ 7. Psychosocial Rehabilitation ☐ 8. Targeted Case Management ☐ 9. Other, specify	_		
Nursing Facility Activities	☐ Yes	☐ No	
In OBRA process	☐ Yes	☐ No	
Diagnosis(es)	□ SMI □ MR	□ RC □ MR/RC	DUAL O MI/MR O MI/RC
DMHMRSAS Determination Rationale:			O MI/RC

		*	
		H	***************************************
Comments:			
			MITTO-THE ANALYSIS STATE OF THE
			
DMHMRSAS Authority:OBRA Consultant			Date

FAX: (804) 786-1836

Telephone: (804) 371-2134

Virginia PRE-ADMISSION Screening Mental Retardation and/or Related Condition Level II Instrument

SECTION 1: IDENTIFICATION				
1. Name:Last		First		MI
2. Gender: M F	3. DOB:		4. Age:	
5. Private Pay No Yes	6. Medicaid #:	**************************************	7. SSN:	
8. CSB Name: (Catchment area)		9. Evaluation date		-
10. Evaluation location: NF	☐ Hospital ☐ Home	Other (specify):	***************************************	
11. LPASC:		Contact person: _		(Title)
Address:		City	Ctat	e:Zip:
Telephone: ()	4		Jian Jian	دzıp
10.0pnone. ()		•		
12. Per documentation in chart, does If "Yes," complete the following		AL GUARDIAN?	□No	Yes
Name:			Phone#: ()	
Address:		City:	State:	Zip:
Relationship: Parent C	hild Sibling Spouse	Friend Other	r (specify):	
13. DSM-IV Current Diagnoses:	Axis I: Primary		Seconda	ry
				ry
	Axis III: Related Condition			
SECTIONII: PSYCHOSOGIAL				
1. Marital Status: Married	☐ Widowed ☐ Sep.	arated	ed Single	e 🔲 Unknown
2. Education: ☐ Less than high school ☐ Some college ☐ Unknown	☐ Some high so☐ College grad		☐ High school gr ☐ Special Educat	
3. Academic skills (check the box w	hich best describes the reside	ent's functional achieve	ments):	
☐ Yes ☐ No ☐ Yes ☐ No	Can read/recognize simple Can read/recognize 3-4 wc Can read at newspaper lev Can perform simple additi Can perform simple multip	ord sentences el (approx. grade 6) on/subtraction		
4. Last full-time employment/day pr	ogram position held:			

SECTION II: PSYCHO	SOCIAL (Continued		Name:
5. Reasons for admission	TAX MADE UT	MATERIAL PROPERTY CONTRACTOR OF THE PROPERTY O	Conference on the Conference of the Conference o
Cannot manage hous Convalescent care < Decline in ADLs Emergency placeme	se 30 days	☐ Fear for personal safety ☐ Financial problems ☐ Illness/disease ☐ Other (specify):	☐ Isolation ☐ No primary caregiver
6. Is this person able to ev	acuate a building in 3	minutes unassisted? \(\square\) No	☐ Yes
7. Provide history to subst			
		·	
8. Are there current and on	igoing family supports	s?	
Please describe:			
SECTION III: LEVEL OF	EUNCHIONING		
Basic Funtional skills:	Action and the state of the sta	dependent 2=Verbal assistance	2 3=Physical assistance 4= Dependent
() Transferring	() Bladder	() Bowel	у Верением
() Toileting () Bathing	() Self medication () Personal hygiene	() Eating	() Prepares for bed () Dressing/undressing () Selecting appropriate about
_		() Dinaming	() Selecting appropriate clothes
2. Advanced Functional sld	ills: $Coding$ $l = In$	adependent 2=Verbal assistance	e 3=Physical assistance 4= Dependent
() Care of clothing () Meal preparation	() Use of telephone() Use of transporta() Shopping() Understands time	ntion () Manage finances () Use of leisure time	() Goes outdoors safely () Treat minor ailments () Monitor health status ies () Attend medical appts.
3. Cognitive skills:	Coding $l = Indepe$	endent 2=Verbal assistance .	3=Physical assistance 4= Dependent
() Prepares for daily activitie () Arranges for transport () Expresses needs and want	() Understa	ands 1 step instructions ands multi-step instructions	() Stays on task () Completes assignments () Transfers skills
Sleep Pattern (mark one)):		
☐ Normal ☐ Proble	ems falling asleep	☐ Problems staying asleep	p Severely disturbed pattern

Name:	
SECTION III: LEVEL OF FUNCTIONING (Continued)	
5. Ambulation (mark one):	A CONTRACTOR OF THE PARTY OF TH
☐ Fully independent ☐ Unsteady ☐ Aids (cane/walker/assisted by 1) ☐ Wheelchair/independent ☐ Chairfast or Posey support ☐ Bedfast ☐ Other (specify):	lent
6. Assistive Devices: Describe the extent to which corrective/assistive/prosthetic/mechanical devices are used an the individual's functional capabilities:	
SECTION:IV: MEDICAL:HISTORY	
 Psychotropic Medication Record any psychotropic medications that have been prescribed and note any changes in dosage in the last three 	op months
Drug Code/Name Purpose Dosage Freq Change Response to	
STAT/PRN Administration of Medication	
In the last 60 days, has the individual received an emergency (STAT) or PRN administration of medication to combehavior? \[\sum \text{No} \sum \text{Yes} \]	
f "yes," please indicate the medication that was administered and the behavior for which the medication was admin	istered:
	W. 1
Physician Review Is a physical examination completed and signed by a licensed physician in the last 12 months attached? Yes, skip, physical examination supplement.	
No, the physical examination supplement must be completed and signed by a licensed physician.	
. Comments:	
QMRP Signature ()	

SECTION V: BEHAVIORA	L ASSESSMENT		Name:	
1. Affective Behavior Observ	- Control of the Cont			
a. Physical Features (mark	: all that apply):			
☐ Clean/Tidy ☐ Careless/Disheve ☐ Makeup or jewel: ☐ Non-seasonal clo	elled/Słoppy Iry	Poor hygiene Normal stree No apparent Other (specif	et dress	Vell-groomed Vearing bedclothes
b. Level of Consciousness	(mark all that apply):			
☐ Alert ☐ Drowsy	☐ Attentive ☐ Inatten	itive 🗆 Lethargic	Other (specify):	
c. Manner (mark all that ap				
☐ Silly ☐ Suspicious ☐	Sincere Apar Easily frustrated Child	eatening thetic Idlike	☐ Concerned about others ☐ Aggressive ☐ Reluctant to Respond	☐ Outgoing nature ☐ Sense of humor ☐ Other (<i>specify</i>):
d. Mood and Affect (mark a				
☐ Appropriate in qua ☐ Flat or blunted ☐ Depressed ☐ Anxious, fearful o ☐ Angry, belligerent ☐ Delusional ☐ Suicidal ☐ Homicidal ☐ Other (specify):	ality and intensity to stated Mild or worried Mild t or hostile Mild Mild Mild Mild	1 1 1 1	☐ Moderate	☐ Severe
e. Form of Thought (check a	ıll that apply):			
☐ Coherent☐ Relevant☐ Logical	☐ Incoherent/Illog☐ Irrelevant/Ramb☐ Loose Associati	bling	☐ Blocking ☐ Impoverished ☐ Perseveration	☐ Tangentiality ☐ Circumstantiality ☐ Pressured
f. Orientation Level (mark on	ne):			لسط ۱ ۱ کی او د کی
Oriented X3; clear Oriented to person Confused at times in Nonresponsive	in day	Oriented X3; for Oriented to situs Confused at tim Unable to determ	nation	nted to person and place nted to bathroom/bed riented X3
g. Communication Ability (ch	ieck all that apply):			
☐ No problems ☐ Inappropriate content	Reads Stammer/stutter/ir	Writes [mpediment [Speech unclear/slurred Eye contact	Gestures/aids Unresponsive
h. Socialization (mark all that	apply):			-
☐ Appropriately respond ☐ Appropriately initiates ☐ Inappropriate respons ☐ Withdrawn	eds to others' initiations es contact with others ses/interactions (describe):			
i. Attitude (mark one):				
☐ Cooperative	☐ Oppositional	☐ Agitated	I Guardeo	1

SECTION V: BEHAVIORAL ASSESSMENT (Continued) 2. Placement in Seclusion/Physical Restraints/Behavior Changes In the last 60 days, has the individual been placed in seclusion or other physical restraints to control dangerous behavior? \square No ☐ Yes If "yes," describe the behavior changes and type of restraints, if applicable: 3. Functional Assessment Summary (ICAP, ABS, etc.) Describe current functional status - improvement or decline. Identify any strengths or weaknesses which may impact the individual's participation in specialized services. Motor Skills (This domain assesses one's sensory and motor abilities. Visual and auditory abilities are examined, as are fine-motor and gross a. Social & Communication Skills (This domain assesses receptive and expressive abilities and how one utilizes those skills to make needs b. and requests known. This area also assesses the individual's ability to interact with others.) Personal Living (This domain pertains to eating, toileting, maintaining a clean, neat appearance, taking care of clothing, dressing and C. undressing, etc.) Community Living (This area addresses skills relating to handling money, telling time, acting responsibility, preparing meals, doing laundry, d. Broad Independence (This area addresses the individual's overall ability to take care of him/herself and interact in his environment.) e. f. Problem Behaviors (Describe any behaviors which are disconcerting or upsetting to others, such as inappropriate physical contact, stereotypical or being overly active. Included in this domain may be behaviors that relate to sexual activity in socially unacceptable ways and behaviors that cause harm to oneself. Describe any behavior strategies that have been implemented and their impact on the behavior.)

SECTION VI: DETERMINATION RECOMMENDATION					
1. Name:					
Last	First			MI	
2. SSN:	3. Medicaid#:			***	
4. The individual has, or may have, a diagnosis of mental illness	e?				
□ No					
Yes If yes, specify diagnosis 5. Does the individual meet the DSM-IV criteria for mental retains					
No Yes, check at least one of the following and substant		m 6 (include co	ny of ago		
☐ Mild ☐ Moderate ☐ Sev		Profound	py or assessm	ent)	
6. Cognitive test (specify):		Date performe	d.		
Verbal IQ Perf IQ					
Administered by:	Title:	1 1111 50	ale IQ		
				- 1000	
7. Does the individual meet the DSM-IV criteria for a related con					
☐ No, if the answer to question 5 was also no, stop here ☐ Yes, check at least one of the following:	e and sign on page 7.				
☐ Blindness ☐ Hem ☐ Cerebral Palsy ☐ Hem ☐ Deafness ☐ Hydr ☐ Encephalitis ☐ Men ☐ Epilepsy/seizures ☐ Micr	rocephaly		uscular Dystro raparesis raplegia lio adriplegia na Bifida nal Cord Inju		
8. Check the box that best describes the individual's functional level in each of the following areas:					
	Independent	Minimal	Moderate	Unable	
a. Takes care of most personal needs					
b. Understands most simple commands					
c. Communicates basic needs and wants					
 d. Is employed at a productive wage w/o long term supervision/support 				П	
e. Learns new skills w/o aggressive and consistent training	ıg 🔲		П		
f. Generalizes trained skills to other environments w/o aggressive and consistent training					
g. Demonstrates behaviors appropriate to time, situation, and place w/o supervision			<u> </u>	П	
h. Makes decisions requiring informed consent					

Name:

		Name:
SECTION VI: DETERMINATION RECOMMENDATION	N (Continued)	
9. SPECIALIZED SERVICES RECOMMENDATION		
Does resident require specialized services? No	☐ Yes	(Mark all that apply):
CURRENT SPECIALIZED SERVICES		RECOMMENDATIONS Continue Discontinue New
□ 1. Behavior Skills □ 2. Communication □ 3. Community Living Skills □ 4. Resource Utilization Skills □ 5. Day Support and Habilitation □ 6. Education □ 7. Environmental Skills □ 8. Pre-Vocational/Sheltered Employment □ 9. Self-Advocacy □ 10. Self-Help/Personal Care □ 11. Social Skills Development □ 12. Supported Employment □ 13. Task Learning □ 14. Transportation to Specialized Services □ 15. Assistive Technology Evaluation □ 16. Assistive Technology □ 16a. Communication devices □ 16b. Compensatory devices □ 16c. Environmental control devices □ 16d. Environmental modifications □ 16e. Feeding devices □ 16f. Wheelchair Seating/positioning □ 16g. Wheelchair fitting-customized □ 16h. Mobility aids □ 17. Other adaptive devices (specify): □ Rationale:		1.
Rationale:		
10. SERVICES OF LESSER INTENSITY Does resident require services of lesser intensity? 1. Adjustment needs 2. Basic grooming 3. Behavior management 4. Non-customized durable medical equipment 5. Occupational therapy 6. Physical therapy 7. Restorative nursing 8. Speech-language pathology 9. Sensory stimulation 10. Visual/Hearing 11. Other	□ NO □ YES	ES (Mark all that apply)

11. Print Assessor's Name ______ Title _____ Telephone (____)

Assessor/QMRP Signature ______ Date: _____

Virginia PRE-ADMISSION Screening Dual (MI & MR or MI & RC) Diagnosis Level II Instrument

SECTION I: IDENTIFICATION				
			And the Control of th	And the state of t
1. Name:				
Last		First		MI
				1411
2. Gender: $\square M$ $\square F$	3. DO	B:	4. Age:	
5. Private Pay: ☐ No ☐ Yes	6.Medicaid #: _		7. SSN:	
8. CSB Name:		0 Evaluat	ion Date:	
(Catchme	nt area)	9. Evaluat	ion Date:	
10. Evaluation location: NF	☐ Hospital ☐ Home	☐ Other (<i>specify</i>):		
11. LPASC:		Contrat		
II. LIASC.		Contact person: _		(Title)
				(Title)
Address:		City:	State:	Zip:
Telephone: ()				
12. Per documentation in chart, does	the individual have a LECA	I. CHARDIANS	□ No □ Ye	20
If "Yes", complete the following		D GOMEDIAIT.		~ 5
Name:		Phone i	#: ()	
4.11	G:		_	
Address:	City: _		State:	_ Zip:
Relationship: Parent Ch	ild Sibling Spouse	□ Friend □ Other	- (maciful.	
Relationship. Li Litett Li Cii	nd Li Stotting Li Spouse	LITTER LITTER	(specify):	
13. DSM-IV Current Diagnoses:	Axis I: Primary		Secondary	
	Axis II: Primary		Secondary	
	Axis III. Related Condition	n		
	TIXES III. ROLLING COMMING			***************************************
SECTION II: PSYCHOSOGIAL.				
	5. C.	омители и подражения подражения в подражения в подражения в подражения в подражения в подражения в подражения В подражения в подра	авивния канколуцияния часты на канкона король по при доставля в при доставля в при доставля в при доставля в п В при доставля в при	Bereit 1974 - Arvertament Structure in Bereit er Fr
1. Marital Status: Married	☐ Widowed ☐ Se	parated Divo	arned Cinele	TT-l
1. Maritai Status. 🗀 Married	LI Widowed Li Se	arated L Dive	orced	☐ Unknown
2. Education:		,		
Less than high school	☐ Some high sc	nool	☐ High school graduate	
Some college	☐ College gradı		☐ Special education	
☐ Unknown			•	
3. Academic skills (check the box wl	nich best describes the reside	nt's functional achiev	/ements):	
☐ Yes ☐ No	Can read/recognize simple	words		
Yes No	Can read/recognize 3-4 wo			
Yes No	Can read at newspaper lev			
Yes No	Can perform simple additi			
☐ Yes ☐ No	Can perform simple multip			
				-
4. Last full-time employment/day pro	ogram position held:		***************************************	

	Name:	
SECTION II: PSYCHOSOCIAL (Continu		
5. Reasons for admission (check all that ap	ply):	E MediaPoles to a second to the Performance Symptom of the second to the
☐ Cannot manage house ☐ Convalescent care < 30 days ☐ Decline in ADLs ☐ Emergency placement	☐ Fear for personal safety ☐ Financial problems ☐ Illness/disease ☐ Other (specify):	☐ Isolation ☐ No primary caregiver
6. Is this person able to evacuate a building	g in 3 minutes unassisted? No	Yes
7. Provide history to substantiate MR/RC	diagnosis:	

· ·		
8. Provide history to substantiate MI diagn	Osis:	

9. Are there current and ongoing family su Please describe:	pports?	
SECTION III: LEVEL OF FUNCTION	NG	
1. Basic Funtional skills: Coding	l = Independent $2 = Verbal assistance$	3=Physical assistance 4= Dependent
() Transferring () Bladder () Toileting () Self medic () Bathing () Personal h		() Prepares for bed() Dressing/undressing() Selecting appropriate clothes
2. Advanced Functional skills: Coding	I = Independent 2=Verbal assistance	3=Physical assistance 4= Dependent

2

() Use of Money

() Manage finances

() Use of leisure time

() Respond to emergencies

() Goes outdoors safely

() Treat minor ailments

() Monitor health status

() Attend medical appts.

() Use of telephone

() Shopping() Understands time

() Use of transportation

() Housework

() Employment

() Care of clothing

() Meal preparation

Name:
SECTION III: LEVEL OF FUNCTIONING: (Continued)
3. Cognitive skills: Coding $l = Independent$ $2 = Verbal \ assistance$ $3 = Physical \ assistance$ $4 = Dependent$
() Prepares for daily activities () Understands 1 step instructions () Arranges for transport () Understands multi-step instructions () Expresses needs and wants () Learns new skills () Transfers skills
4. Sleep Pattern (mark one):
□ Normal □ Problems falling asleep □ Problems staying asleep □ Severely disturbed pattern
5. Ambulation: (check as needed to describe resident's ability to ambulate)
☐ Fully independent ☐ Unsteady ☐ Aids (cane/walker/assis.by 1) ☐ Wheelchair/indep. ☐ Wheelchair/assisted ☐ Chairfast or Posey support ☐ Bedfast ☐ Other (specify):
6. Assistive Devices : Describe the extent to which corrective/assistive/prosthetic/mechanical devices are used and/or could improve the individual's functional capabilities:
SECTION IV: MEDICAL HISTORY
1. Psychotropic Medication Record any psychotropic medications that have been prescribed and note any changes in dosage in the last three months.
Drugs Code/Name Purpose Dosage Freq Change Response to Rx
2. STAT/PRN Administration of Medication
In the last 60 days, has the individual received an emergency (STAT) or PRN administration of medication to control her/his
behavior?
If "yes," please indicate the medication that was administered and the behavior for which the medication was administered:
3. Physician Review Is a physical examination completed and signed by a licensed physician in the last 12 months attached? Yes, skip, physical examination supplement. No, the physical examination supplement must be completed and signed by a licensed physician.
4. Comments:
5. QMRP Signature Telephone: () Date:

SECTION V:BEHAVIORAL AND PSYCHIATRIC ASSESSMENT 1. Affective Behavior Observations a. Physical Features (mark all that apply): Clean/Tidy
a. Physical Features (mark all that apply): Clean/Tidy
Clean/Tidy
□ Careless/Dishevelled/Sloppy □ Normal street dress □ Wearing bedclothes □ Makeup or jewelry □ No apparent effort at personal appearance □ Non-seasonal clothing □ Other (specify): b. Level of Consciousness (mark all that apply): □ Alert □ Drowsy □ Attentive □ Inattentive □ Lethargic □ Other (specify): c. Manner (mark all that apply): □ Warm □ Shy □ Threatening □ Concerned about others □ Outgoing nature □ Silly □ Sincere □ Apathetic □ Aggressive □ Sense of humor □ Suspicious □ Easily frustrated □ Childlike □ Reluctant to Respond □ Other (specify): d. Mood and Affect (mark all that apply):
b. Level of Consciousness (mark all that apply): Alert Drowsy Attentive Inattentive Lethargic Other (specify): C. Manner (mark all that apply): Warm Shy Threatening Concerned about others Silly Sincere Apathetic Aggressive Sense of humor Suspicious Easily frustrated Childlike Reluctant to Respond Other (specify): d. Mood and Affect (mark all that apply):
c. Manner (mark all that apply): Warm Shy Threatening Concerned about others Silly Sincere Apathetic Aggressive Sense of humor Reluctant to Respond Other (specify): d. Mood and Affect (mark all that apply):
□ Warm □ Shy □ Threatening □ Concerned about others □ Outgoing nature □ Silly □ Sincere □ Apathetic □ Aggressive □ Sense of humor □ Suspicious □ Easily frustrated □ Childlike □ Reluctant to Respond □ Other (specify): d. Mood and Affect (mark all that apply): □ Other (specify): □ Other (specify):
☐ Silly ☐ Sincere ☐ Apathetic ☐ Aggressive ☐ Sense of humor ☐ Childlike ☐ Reluctant to Respond ☐ Other (specify): d. Mood and Affect (mark all that apply):
Appropriate in quality and intensity to stated themes
Flat or blunted Depressed Mild Moderate Severe Anxious, fearful or worried Mild Moderate Severe Angry, belligerent or hostile Mild Moderate Severe Delusional Mild Moderate Severe Severe Severe Mild Moderate Severe Severe Mild Moderate Severe Mild Moderate Severe Homicidal Mild Moderate Severe Other (specify): Severe
e. Form of Thought (check all that apply):
□ Coherent □ Incoherent/Illogical □ Blocking □ Tangentiality □ Relevant □ Irrelevant/Rambling □ Impoverished □ Circumstantiality □ Logical □ Loose Associations □ Perseveration □ Pressured
f. Orientation Level (mark one):
☐ Oriented X3; clear at all times ☐ Oriented X3; forgetful at times ☐ Oriented to person and place ☐ Oriented to person ☐ Confused at times in day ☐ Confused at times at night ☐ Nonresponsive ☐ Unable to determine ☐ Oriented to person and place ☐ Oriented to bathroom/bed ☐ Disoriented X3
g. Communication Ability (check all that apply):
☐ No problems ☐ Reads ☐ Writes ☐ Speech unclear/slurred ☐ Gestures/aids ☐ Inappropriate content ☐ Stammer/stutter/impediment ☐ Eye contact ☐ Unresponsive
h. Socialization (mark all that apply):
Appropriately responds to others' initiations Appropriately initiates contact with others Inappropriate responses/interactions (describe):
i. Attitude (mark one):
☐ Cooperative ☐ Oppositional ☐ Agitated ☐ Guarded

Name	:

SECTION V. BEHAVIORAL AND PSYCHIAERIC A 2. Chart of Behavior Complete the chart based of	And the second s	
the individual's medical reco	n all available information for the last 3 mo ords and staff comments:	nths, including information fr
Frequency		Frequency
Dangerous smoking behavior	Destroys property	
Refuses medications	Exposes self	
Uncooperative diet	☐ Is sexually aggressive	
Uncooperative hygiene	Abusesverbally	
Refuses activities	Threatensverbally	
Refuses to eat	Threatensphysically	
Self-induces vomiting	Strikes othersprovoked	
☐ Impatient/demanding		
Frequent/continuous yelling	•	
☐ Wanders	Suicidal threats	
Tries to escape	Suicidal attempts	
☐ Seclusiveness	Injures self	
Suspicious of others	_ Other (<i>specify</i>):	
Lies purposefully	_ ☐ Other (specify):	
Steals deliberately		
Placement in Seclusion/Physical Restraints/Behavior	Change(s)	
In the last 60 days, has the individual been placed in sec		
□ No □ Yes	control of other physical restraints to control	dangerous behavior?
If "yes," describe the behavior and type of restraints:		
y , assessed the benarior and type of restraints.		
Comments:		
Comments:		

	Name:
SECTION V: B)	EHAVIORAL AND PSYCHIATRIC ASSESSMENT (Continued)
4. Functional A	ssessment Summary (ICAP, ABS, etc.)
Describ individi	e current functional status - improvement and/or decline. Identify any strengths or weaknesses which may impact the ual's participation in specialized services.
a.	Motor Skills (This domain assesses one's sensory and motor abilities. Visual and auditory abilities are examined, as are finemotor and gross motor skills.)
b.	Social & Communication Skills (This domain assesses receptive and expressive abilities and how one utilizes those skills to make needs and requests known. This area also assesses the individual's ability to interact with others.)
c.	Personal Living (This domain pertains to eating, toileting, maintaining a clean, neat appearance, taking care of clothing, dressing and undressing, etc.)
d.	Community Living (This area addresses skills relating to handling money, telling time, acting responsibility, preparing meals, doing laundry, etc.)
e.	Broad Independence (This area addresses the individual's overall ability to take care of him/herself and interact in his environment.)
	·

<u>Problem Behaviors</u> (Describe any behaviors which are disconcerting or upsetting to others, such as inappropriate physical contact, stereotypical or being overly active. Included in this domain may be behaviors that relate to sexual activity in socially unacceptable ways and behaviors that cause harm to oneself. Describe any behavior strategies that have been implemented and

f.

their impact on the behavior.)

SECTION VE DUAL DETERN	IINATION RECOMI	MENDATION			
1. Name:				And the second s	Company of the second s
Last		First	W		
2. SSN:		3. Medicaid a	Ψ:		
4. Door the individual and a v					
4. Does the individual meet the I	OSM-IV criteria for me	ental retardation?)		
☐ No ☐ Yes, check at least o	ne of the following and	substantiate by	completing item 5	(include copy of a	assessment)
	Moderate	☐ Severe		Profound	,
5. Cognitive test (specify):		Date performed:			
Verbal IQ	Peri	f IQ		Full Scale IQ	
Administered by:			Title:		
6. Does the individual meet the D					
☐ No☐ Yes, check at least on	e of the following:				
□ BI □ Ce □ De □ Er □ Ep □ Fr	utism indness erebral Palsy eafness ncephalitis pilepsy/seizures iedreich's Ataxia her; specify:	□ H □ H □ M □ M	ead Injury emiparesis emiplegia ydrocephaly eningitis icrocephaly ultiple Sclerosis		Muscular Dystrophy Paraparesis Paraplegia Polio Quadriplegia Spina Bifida Spinal Cord Injury
7. Check the box that best describe	es the individual's fund	ctional level in e	ach of the followin	g areas:	
		Independent	Minimal	Moderate	Unable
a. Takes care of most per	rsonal needs				
b. Understands most sim	ple commands				
c. Communicates basic n	eeds and wants				
d. Is employed at a produ long term supervision/					
e. Learns new skills w/o consistent training	aggressive and				
 f. Generalizes trained skill environments w/o aggre- consistent training 					
g. Demonstrates behavior time, situation, and pla	s appropriate to ace w/o supervision				
h. Makes decisions requir	ing informed consent				

Name:

SECTION VI: DETERMINATION RECOMMENDA	IION (Continued)				
8. SPECIALIZED SERVICES RECOMMENDATION	N - MR	/RC				
Does resident require specialized services? No		Yes	(Mai	rk all that ap	ply):	
CURRENT SPECIALIZED SERVICES					MENDAT Discontinue	
□ 1. Behavior Skills □ 2. Community Living Skills □ 4. Resource Utilization Skills □ 5. Day Health and Habilitation □ 6. Education □ 7. Environmental Skills □ 8. Pre-Vocational/Sheltered Employment □ 9. Self-Advocacy □ 10. Self-Help/Personal Care □ 11. Social Skills Development □ 12. Supported Employment □ 13. Task Learning □ 14. Transportation to Specialized Services □ 15. Assistive Technology Evaluation □ 16. Assistive Technology □ 16a. Communication devices □ 16b. Compensatory devices □ 16c. Environmental control devices □ 16d. Environmental modifications □ 16e. Feeding devices □ 16f. Wheelchair Seating/positioning □ 16g. Wheelchair fitting-customized □ 16h. Mobility aids □ 17. Other adaptive devices (specify):			1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16a. 16b. 16c. 16d. 16e. 16f. 16g. 16h.	0000000000000000000000000	000000000000000000000000000	0000000000000000000000000
Rationale:						
9. SERVICES OF LESSER INTENSITY - MR/RC						
Does resident require services of lesser intensity? 1. Adjustment needs 2. Basic grooming 3. Behavior management 4. Non-customized durable medical equipment 5. Occupational therapy 6. Physical therapy 7. Restorative nursing 8. Speech-language pathology 9. Sensory stimulation 10. Visual/Hearing 11. Other		□ NO □ YES				ll that apply)
Print Assessor's Name Assessor/OMRP Signature				•	(
Assessor/QMRP Signature			_ Dat	e:		

SECTION VI: DETERMINATION RECOMMENDATION (Continued)
10. As substantiated by your evaluation, does the individual meet the DSM-IV criteria for dementia or a related disorder in the absence of a <u>primary</u> major mental illness?
☐ No, continue ☐ Yes, substantiate below, stop here and sign on page 10
Rationale:
11. As a result of a major mental disorder, the individual has functional limitations in the following areas (mark all that apply):
a. Interpersonal functioning
□ 1. Difficulty interacting appropriately/communicating effectively with other persons □ 2. A history of altercations, evictions, firing, fear of strangers □ 3. Avoids interpersonal relationships □ 4. Is socially isolated □ 5. Other (specify): □ 6. None
b. Concentration, persistence and pace
 □ 1. Difficulty in sustaining focused attention to complete work tasks □ 2. Difficulty in sustaining focused attention to complete home tasks □ 3. Inability to complete tasks within established time period □ 4. Makes frequent errors or requires assistance in the completion of tasks □ 5. Other (specify):
c. Adaptation to change
 □ 1. Difficulty in adapting to typical changes associated with work, school or family □ 2. Manifests agitation, exacerbated signs and symptoms associated with the illness □ 3. Withdraws from the situation □ 4. Requires intervention by MH or judicial systems □ 5. Other (specify): □ 6. None
12. As a result of a major mental disorder, the individual has required treatment within the last two years for:
☐ Psychiatric treatment more intensive than outpatient care ☐ Episodes of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officers ☐ None
Does the individual meet the DSM-IV criteria for a serious mental illness? No Yes, check at least one of the following and substantiate below (P=primary S=secondary) PS □□1. Anxiety disorder □□2. Atypical psychosis □□9. Paranoid disorder □□3. Bi-polar disorder □□4. Delusional disorder □□15. Depression □□15. Somotoform disorder □□16. Major affective disorder □□17. Mood disorder □□18. Panic disorder □□19. Schizoaffective disorder □□10. Schizoaffective disorder □□11. Schizophrenia □□12. Somotoform disorder □□13. Other (specify): □□17. Mood disorder □□14. Other (specify): □□17. Mood disorder
Rationale:

	Name:	
SECTION VI: DETERMINATION RECOMMENDATION (Continued)		
14. SPECIALIZED SERVICES RECOMMENDATION - Mental Illness		
Does the individual require specialized services for SMI (Inpatient psychiatric l	nospitalization)?	
□ No □ Yes, substantiate below	•	
Rationale:		
·		
15. MENTAL HEALTH SERVICES RECOMMENDATION - Mental Illness		
Does resident require Mental Health Services of a lesser intensity?	□No	(Mark all that apply)
CURRENT MENTAL HEALTH SERVICES	RECOMMENDATIONS Continue Discontinue New	
1. Psychiatric consultation 2. Behavior management 3. Day treatment/partial hospitalization 4. Crisis intervention 5. Outpatient psychiatric 6. Psychotropic medication management 7. Psychosocial rehabilitation 8. Targeted care management 9. Other, specify	1.	
		,
Printed name:Title:	Telephon	ne #: ()
Psychiatrist/QMHP Signature:		